Supreme Court, U.S.
FILED

991666 FEB 16 2000

OFFICE OF THE CLERK

IN THE

SUPREME COURT OF THE UNITED STATES

UNITED STATES OF AMERICA, ex rel.
CORNELIUS HARRIS

Petitioner

v.

GEORGE WASHINGTON PRIMARY
CARE ASSOCIATES, et al.

Respondent

On Petition for Writ of Certiorari
To the United States Court of Appeals

PETITION FOR WRIT OF CERTIORARI

David E. Fox
1325 18th Street, NW
Suite 103
Washington, DC 20036
(202) 955-5300

139pp

Questions Presented for Review

I. Whether the United States Court of Appeals for the District of Columbia Circuit entered a decision in conflict with the decisions of other Courts of Appeal on an important federal question.

II. Whether the appellant provided a statement of claim which could fairly allow the Appellee to understand the allegations and fashion an answer as is required by FRCP 9(b) of the Federal Rules of Civil Procedure.

III. Whether the appellant was entitled to a relaxed pleading standard when alleging fraud where the specific facts alleged and proof thereof are peculiarly within the control of defendant.

IV. Whether the Court abused its discretion when it dismissed the case after hearing counsel for Appellees' testify as to unsubstantiated and improper character allegations about the relator.

V. Whether the trial court must allow limited discovery in a fraud action when the specific facts needed to prove the fraud are peculiarly within the control of the defendant.

PARTIES

I. Appellant

United States of America, ex rel.

Cornelius Harris

Attorney for Appellant

David E. Fox, Esq.
1325 18th Street, NW
Suite 103
Washington, DC 20036
(202) 955-5300

II Appellees

George Washington Primary Care Associates
Health Care Sciences
Medical Faculty Associates
George Washington Department of Medicine
George Washington Hospital
Judith McManus
Joshua Cohen
John Doe, I thru X

Attorneys for Appellees

J. Stephen Lawrence, Esq.
Richard S. Ewing, Esq.
ARNOLD and PORTER
555 12TH Street, NW

Washington, DC 20004-1202
(202) 942-5000

William F. Howard, Esquire
Betsy Wagner, Esquire
Office of the Vice President and General Counsel
The George Washington University
2100 Pennsylvania Avenue, NW
Washington, DC 20052
(202) 994-6503

III. United States of America

Scott S. Harris, Esq.
Assistant U.S. Attorney
Judiciary Center Building
555 4th Street, NW
Room 10-818
Washington, DC 20001

TABLE OF CONTENTS

Questions Presented for Review i

Parties ii

Table of Authorities v

Citations vii

Statement of Jurisdiction vii

Statutory Provisions vii

Statement of Facts 1

Argument .....

I. Whether the United States Court of Appeals for the District of Columbia Circuit entered a decision in conflict with the decisions of other Courts of Appeal on an important federal question. 3

II. Whether the appellant provided a statement of claim which could fairly allow the Appellee to understand the allegations and fashion an answer as is required by FRCP 9(b) of the Federal Rules of Civil Procedure. 7

III. Whether the appellant was entitled to a relaxed pleading standard when alleging fraud where the specific facts alleged and proof thereof are peculiarly within the control of defendant. 11

IV. Whether the Court abused its discretion when it dismissed the case after hearing counsel for Appellees' testify as to unsubstantiated and improper character allegations about the relator. 17

V. Whether the trial court must allow limited discovery in a fraud action when the specific facts needed to prove the fraud are peculiarly within the control of the defendant. 19

Appendix A (Statutory Provisions and Orders) A1

Appendix B (Plaintiff's Amended Complaint) B1

Appendix C (Motions Hearing Transcript) C1

TABLE OF AUTHORITIES

CASES

Christidis v. First Pennsylvania Mortgage Trust, 717 F.2d 96 (3rd. Cir. 1983) 6

Crane v. Carr, 814 F.2d 758 (D.C. Cir 1987) 20

Fridlander v. Nims, 755 F.2d 810 (1985) 3,4,12

Gopez v. Shinn, 736 F. Supp. 51 (D. Del. 1990)..... 6

GTE New Media Services, Inc. v. Bellsouth Corporation, U.S. App. D.C. No. 99-709 20

Harrison v. Westinghouse Savanah River Co., 176 F.3d 776, (4th Cir. 1999) 8,12

Hayduk v. Lanna, 775 F.2d 441 (1985) 12

Kowal v. MCI Communications Corp., 16 F.3d 1271 (D.C. Cir 1994) 4,5,8

Picard Chemical Inc. Profit Sharing Plan v. Ferrigo, 940 F. Supp. 1101 (W.D. Mich. 1996) 11,12

United States ex rel. Cannon v. Joseph, 642 F.2d 1373 (D.C. Cir. 1981), *cert denied*, 405 U.S. 999 (1982) 3,4,8

United States ex rel. Stinson and Lyons v. Blue Cross, 755 F. Supp. 1090 (S.D. Ga. 1990) 12

United States ex rel. Thompson v. Columbia/HCA Healthcare Corporation, et al., 125 F.3d 899 (5th Cir. 1997) 3,5

Wexner v. First Manhattan Co., 902 F.2d 169 (2nd Cir. 1990) 3,4,11

STATUTES and RULES

31 U.S.C.A §3729-3731 1,16

Fed. R. Civ. P. 8 ..... passim

Fed. R. Civ. F. 9(b) ..... passim

Federal Rule of Evidence 405 18

Federal Rule of Evidence 608 18

Citations

This case is on Appeal from:

USDC No. 97cv01605 (United States District Court for the District of Columbia)

appealed to:

USCA 98-7192 (United States Court of Appeals)

Jurisdiction

This case is on appeal from an order dated October 19, 1999 denying Appellants appeal of dismissal from the United States District Court for the District of Columbia and November 18, 1999 denying rehearing for same.

Statutory Provisions

False Claims Act, 31 U.S.C.A. §3729-3731
Federal Rule of Civil Procedure 8
Federal Rule of Civil Procedure 9(b)
Federal Rule of Evidence 405
Federal Rule of Evidence 608

Statement of Facts

Appellant Cornelius Harris worked for Appellees George Washington University Hospital, a group of doctors known as George Washington Primary Care Associates and their affiliates as a Medicare reimbursement specialist. He filed an action in the United States District Court for the District of Columbia as a Relator under the False Claims Act, 31 U.S.C.A. §3729-3731 alleging actions on the part of Appellants that constituted fraud. An action brought under the Federal Claims Act is an action based on a Federal Question. Thus, jurisdiction is proper.

The Relator supplemented his complaint with an amended complaint identifying a history of false claims including upcoding and improper coding of medical services on the part of Appellee. He specified the specific Medicare regulations and Code of Federal Regulations that were violated and pled that when he attempted to bring these practices to his supervisors, he was told by Appellees to

"leave it alone."

Appellee filed a Motion to Dismiss under FRCP 9(b) arguing that the Complaint did not meet the standards of pleading with particularity required by FRCP 9(b) when pleading fraud. A short hearing on the Motion was held.

At the hearing on the Motion to Dismiss, Appellee's counsel made derogatory statements impugning Appellant's character. The District Court immediately granted Appellee's Motion and dismissed the claim without prejudice.

The Relator filed an appeal with the United States Court of Appeals which scheduled oral arguments, then, a mere ten days prior, canceled oral argument *sua sponte* and ruled on the briefs alone. The Relator filed a Motion for Reconsideration and a request for oral argument, both of which were denied. The Relator now appeals the decision to dismiss to this Court.

ARGUMENT

I. Whether the United States Court of Appeals for the District of Columbia Circuit entered a decision in conflict with the decisions of other Courts of Appeal on an important federal question.

There is an inherent inconsistency between the various rulings of the Circuits. At least three circuits allow pleading on information and belief when the facts necessary to plead with particularity as required by FRCP 9(b) are peculiarly within the dominion and control of the Defendant. See United States ex rel. Thompson v. Columbia/HCA Healthcare Corporation, et al., 125 F.3d 899 (5th Cir. 1997); Wexner v. First Manhattan Co., 902 F.2d 169 (2nd Cir. 1990); Friedander v. Nims, 755 F.2d 810 (1985). In contrast, the Circuit Court for the District of Columbia more narrowly defines FRCP 9(b). The dispositive case in the D.C. Circuit is United States ex rel. Cannon v. Joseph, 642 F.2d1373 (D.C. Cir. 1981), *cert denied* 405 U.S. 999 (1982). Cannon holds that to comply

with the specificity requirements of FRCP 9(b), the complaint must plead the time, place or content of the alleged false misrepresentations, the fact misrepresented, and what was obtained or given up as a consequence of the fraud.

This case makes no allowance for a relaxed standard. Nor does it make allowance for a case like the one at bar where the Relator describes the fraud in generic terms ("upcoding" resulting in higher Medicare billing), states that he saw the bills with his own eyes, but does not name the patient(s), the date(s) of service, or the medical procedure(s) performed as he does not remember the details of each patients' medical chart.

In its opinion in the case at bar, the Court of Appeals stated that it had harmonized FRCP 9(b) with FRCP 8 using the standards set out in Kowal v. MCI Communications Corp., 16 F.3d 1271(D.C. Cir. 1994). However, the court failed to elucidate how such harmony was reached.

Canon and Kowal conflict with Friedlander, Wexner,

and Thompson. The cases from other Circuits stand for the proposition that the courts should harmonize FRCP 9(b) with FRCP 8, relax the specificity standard when the information needed is peculiarly within the control of the Defendant, and allow pleading on information and belief as long as the complainant sets forth the factual basis for such belief. Canon, on the other hand, is narrow to the extreme in its analysis of FRCP 9(b). Kowal is silent as to the issue of harmonizing FRCP 9(b) with FRCP 8. Nor does it relate in any way to a case where plaintiff fails to plead with specificity because the particular facts necessary to show fraud are peculiarly within the control of the Defendant. Kowal does state that plaintiffs pleading on" information and belief" must aver facts upon which their belief is based. However, this mere statement of alleging facts with information and belief pleading does not rise to the level of relaxing the FRCP 9(b) standard in the manner accepted by the 2nd, 5th, and 11th Circuits. Thus, the United States Court of Appeals has

entered a decision in conflict with the decisions of other Courts of Appeal on an important federal question.

The United States District Court for the District of Delaware ruled on a case that is further instructive on this point. See Gopez v. Shin, 736 F. Supp. 51 (D. Del. 1990). This case stands for the proposition that when a stockbroker is charged by a client with "churning", the court said such allegations need not be pled with particularity.

> In applying the first sentence of Rule 9(b) courts must be sensitive to the fact that its application, prior to discovery, may permit sophisticated defrauders to successfully conceal the details of their fraud. Moreover, in applying the rule, focusing exclusively on its "particularity" language "is too narrow an approach and fails to take account of the general simplicity and flexibility contemplated by the rules."

Christidis v. First Pennsylvania Mortgage Trust, 717 F.2d 96, 99-100 (3rd Cir. 1983).

In the case at bar, Appellees are the sophisticated defrauders that are hiding behind the unclear language of the

rules to conceal their fraud. Allowing Appellees to do this frustrates the purpose of the False Claims Act and denies Appellant the ability to bring his claim. It is not inappropriate to liken this Appellee to a stockbroker who is "churning" his clients' accounts to generate fees. This Appellee is "churning" (i.e. "upcoding" and "overbilling") its Medicare claims to generate fraudulent reimbursement from the government, thus, this case must be afforded the same pleading standards of similar cases. The case law bears out the real intent of FRCP 9(b) and the Circuit Court for the District of Columbia is not in line with the other Circuits.

II. Whether the Appellant provided a statement of claim which could fairly allow the appellee to understand the allegations and fashion an answer as is required by FRCP 9(b) of the Federal Rules of Civil Procedure.

FRCP 9(b) requires that in cases of fraud, the circumstances constituting fraud or mistake shall be stated with particularity. A long line of cases supports this rule. See

generally United States ex. rel Cannon v. Joseph, 642 F.2d 1373, 1385 (D.C. Cir. 1981), cert. denied, 455 U.S. 999 (1982). To satisfy Rule 9(b), allegations of fraud must specify "the time, place and content of the false misrepresentations, the fact misrepresented and what was retained or given up as a consequence of the fraud." See Kowal v. MCI Communications Corp., 16 F.3d 1271, 1278 (D.C. Cir. 1994) (quoting Cannon, 642 F.2d at 1385). One of the rule's purposes is to prevent complaints from being filed as a pretext for the discovery of unknown wrongs. Kowal, 16 F.3d at 1279 n.3. The rule also serves to discourage potential plaintiffs from embarking on fishing expeditions. See Harrison v. Westinghouse Savanah River Co., 176 F.3d 776 (4th Cir. 1999).

In the case at bar, the Relator meets the time, place, content, requirements of Cannon. First, the Relator alleges that between 1986 and 1997, instances of improper billing, upcoding, and improper "write-offs" occurred. This meets

the time requirement of the rule. Second, the Relator claims that George Washington University Hospital and its affiliates, all medical service providers, engaged in this improper billing, upcoding and the like. These allegations serve to put the Appellee on notice as to "where" in that the improper actions were taking place at the various billing offices of these facilities. In response to the requirement of the content of the false misrepresentations, the relator lays out with specificity that the Appellees engaged in 1) over billing; 2) improper billing 3) improper resident billing, 4) charges tendered without proper documentation; and 5) improper Medicare "write-offs". These categories correspond to the Medicare regulations. Finally, in a manner consonant with the strictures of Cannon and Kowal, the Relator alleges that these false and fraudulent bills were submitted to the United States as Medicare claims and George Washington Hospital, et al., received, over the course of eleven years, approximately $30,000,000.00 in fraudulent Medicare reimbursement.

While some of the Relator's claims are based upon information and belief, a majority of the Relator's claims set forth the necessary specificity to come within FRCP 9(b) as they serve to put the Defendant on notice of the claims against it. The Appellee could readily have denied these allegations in its answer.

In terms of FRCP 8, the Plaintiff must set forth a clear statement of its claim; that Medicare fraud was the gravamen and violation of Medicare regulation occurred by "upcoding", "over billing", "improper billing", all practices correlated to CFR regulations. The purpose of FRCP 9(b) and the pleading needs of this Appellee would not have been further served by an elucidation that "Patient Jones" should have been billed for a "level I" heart procedure when in fact Medicare was billed for a "level III" procedure. The Appellees' answer to the complaint would be to deny wrongdoing and this would not change if the complaint had specified that Medicare fraud occurred when Appellees overbilled for patient treatment for

thousand of patients including "over billing" "Patient Jones and other patients".

III. Whether the Appellant was entitled to a relaxed pleading standard when alleging fraud where the specific facts alleged and proof thereof are peculiarly within the control of defendant.

When information needed to state fraud with particularity, as required by FRCP 9(b), is only within the opposing party's knowledge and control, complainant may plead upon "information and belief", provided that pleading is accompanied by statement of facts upon which belief is founded. Picard Chemical Inc., Profit Sharing Plan v. Ferrigo 940 F.Supp. 1101 (W.D. Mich. 1996). When the factual information is peculiarly within the Defendant's knowledge and control, FRCP 9(b) is relaxed. Wexner v. First Manhattan Co., 902 F.2d 169, 172 (2nd Cir. 1990). When the facts necessary for specific pleading are exclusively within the

control of the Defendant, FRCP 9(b) must be read in harmony with FRCP 8 requiring Plaintiff's claim to be short and plain. United States ex rel. Stinson Lyons, et al. v. Blue Cross 755 F.Supp. 1090 (S.D.Ga. 1990).

The pleader must file a statement of facts with the complaint if the pleader wishes to come under the relaxed pleading standard. See Picard. The facts must amount to more than the mere suspicion that fraud may have occurred. See U.S. ex rel. Stinson. Rule 9(b) is designed to eliminate fraud actions in which all the facts are learned through discovery after a complaint is filed. Freidlander v. Nims, 755 F.2d 810, 813 (1985). Rule 9(b) disallows fishing expeditions. A plaintiff cannot file first then look for a cause of action. See Harrison v. Westinghouse Savannah River Co., 176 F.3d 776 (4th Cir. 1999); Hayduk v. Lanna, 775 F.2d 441 (1985).

In this case, the Relator was limited in his ability to plead with the requisite particularity because the facts

necessary to prove the fraud were peculiarly within the control of the Defendant. The facts needed to prove the fraud allegations are contained in thousands of patient medical files. These files are located at Appellees Hospital and medical facilities and are protected under patient privilege and confidentiality laws. Though the Relator did in fact see these files while employed by Defendant, he did not make copies or simply walk out of the Appellees' offices with these confidential records. The Relator did not have the proper authorization from the patients nor did he have court authority to take the files or copies prior to filing his lawsuit. Therefore, any removal of any patient files or billing records would have breached the confidentiality and privacy privileges of the patients and also could have resulted in the Relator facing charges that he improperly removed property. Relator chose not to commit these violations.

The Relator created a list of some 1100 names in which he knew the alleged fraud and false claims took place.

However, this record existed only on his computer hard drive or green bar computer paper which he was unable to take with him upon termination of his employment. At the time the complaint was filed, the Relator was unable to remember any, except two or three, of the specific patient names, dates, or medicare violations that would be required to meet the FRCP 9(b) pleading standard. Even though he was still employed by the Defendant at the time the complaint was filed, the Relator was unwilling to breach the patients' confidentiality and privacy rights. Instead, he relied on the relaxed pleading standard because the facts needed to plead with particularity were peculiarly within the control of the Defendant. In this case, those facts are entitled to a high confidentiality and privilege protection as they are sensitive medical files on thousands of patients.

At the District Court hearing on Appellee's motion to dismiss, Relator's counsel offered the name of a specific family of patients who were involved in a car accident and

stated that Relator remembered that Appellee had improperly billed Medicare (and violated the Medicare regulations) for the treatment of these patients by upcoding and failing to bill insurance or other collateral source providers, which is required by the regulations. Appellee's counsel attacked Relator's counsel saying he had violated patients' privacy by giving out a name. Appellee cannot have it both ways. First they claim that the Relator failed to give specific facts in his allegations. Then, when such specifics are offered, Appellee accuses the Relator of breaching patient confidentialities.

The Relator knows what files and documents to review to support his allegations. They were his files, files that sat on his desk, when he worked for the Appellee. However, as he is no longer an employee of the Appellees he does not have access to the specific files or the computer list he generated. Judge Robertson implied that Relator's are supposed to stick around for years and collect information (effectively spying) on their employers so they may take it to

the Government who will then prosecute the case. In this instance Relator left the employ of the Appellee before he was able to memorize such documents and facts (which would have amounted to well in excess of 1,100 patient files and instances of Medicare fraud). The Relator left in part, because he did not wish to remain a party to defrauding the federal government in his capacity as a reimbursement specialist. Now, the Appellee misuses that honorable exit by bootstraping into a protective rule of court. That protective rule , FRCP 9(b) is being used to protect Appellee from the Congressional intent enunciated in 31 U.S.C.A. §3729-3731. A mere rule of procedure should not serve to frustrate the clear Congressional intent and allow this Appellee to enjoy the proceeds of their fraudulently gotten gains.

The Relator knows of the existence of the documents that can support his allegations. He did not, as Judge Robertson implied, merely see something wrong and decide to file a complaint and hope for some discovery to prove the

claim. This Relator saw thousands of patient files and fee tickets. He held them is his hands. They were on his desk. He knew that his employer was engaging in defrauding the Government. He informed his superiors that they were fraudulently and improperly billing Medicare and was told to "leave it alone." He even went so far as to give a lecture to many of the doctors in the employ of Appellee to advise them of the problems and attempt to instruct them how to properly bill and code for Medicare. The documents and facts needed to prove Relator's case are completely within the dominion and control of the Appellee. Thus, in order to satisfy the Congressional intent this case must be allowed to go forward under the relaxed pleading standard allowed by Rule 9(b) for cases of this type.

IV. Whether the Court abused its discretion when it dismissed the case after hearing Appellee's counsel testify as to unsubstantiated and improper character allegations about the relator.

In all cases in which evidence of character or a trait of character of a person is admissible, proof may be made by testimony as to reputation or by testimony in the form of an opinion. FRE 405. The credibility of a witness may be attacked or supported by evidence in the form of opinion or reputation, but subject to these limitations: (1) the evidence may refer only to character for truthfulness or untruthfulness, and (2) evidence of character of the witness for truthfulness has been attacked by opinion or reputation evidence or otherwise. FRE 608. Mere speculation on the character of a witness by counsel for the adverse party is not contemplated or allowed by the Federal Rules of Evidence.

In the case at bar, the District Court Judge improperly inquired into the Relator's reasons for leaving his employment. Counsel for Appellee responded with vague and unsubstantiated remarks concerning the Relator's "bad" character and such was the reason for his ultimate termination. These improper allusions amounted to improper

character attacks on the Relator. While counsel for Appellee did not specify, he certainly alluded to allegations about the Relator's character.

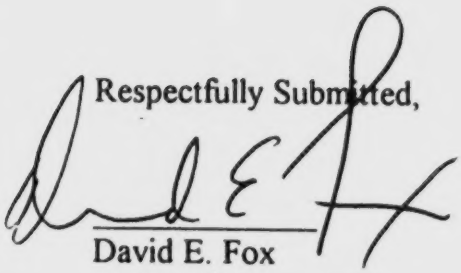
A hearing on a Motion to Dismiss is not the proper forum to attempt to impugn the character of any witness or party to the action. Counsel for Appellee referred to the circumstances of the Relator's departure in such a way as to clearly call Relator's character into issue and make it central to the veracity of his complaint. When taken cumulatively with other facts that may have weighed against the Relator, this inadmissible character attack had to affect or sway the Court in favor of the Appellee.

V. Whether the trial court must allow limited discovery in a fraud action when the specific facts needed to prove the fraud are peculiarly within the control of the defendant.

While there is no specific case law as to this narrow point, there is analogous case law concerning the allowance of

limited and preliminary discovery. The U.S. Court of Appeals for the D.C. Circuit, in a recent opinion held that when a party can substantiate its jurisdictional allegations through discovery, then jurisdictional discovery is justified. See GTE New Media Services, Inc. v. Bellsouth Corporation, U.S. App. D.C. No. 99-7097; citing Crane v. Carr 814 F.2d 758 (D.C. Cir. 1987). It follows in the case at bar where the particular facts needed to plead with the requisite specificity are peculiarly within the dominion and control of the Appellees, and Appellant is therefore entitled to plead on information and belief, that due process and fundamental fairness require limited discovery before a hearing on a motion to dismiss or Motion for Summary Judgment is proper.

Respectfully Submitted,



David E. Fox
1325 18th Street, NW
Suite 103
Washington, DC 20036
(202) 955-5300

Counsel for Appellant

STATUTORY PROVISIONS

FRCP 8. General Rules of Pleading

(a) Claims for Relief. A pleading which sets forth a claim for relief, whether an original claim, counterclaim, cross-claim, or third-party claim, shall contain (1) a short and plain statement of the grounds upon which the court's jurisdiction depends, unless the court already has jurisdiction and the claim needs no new grounds of jurisdiction to support it, (2) a short and plaint statement of the claim showing that the pleader is entitled to relief, and (3) a demand for judgment for the relief the pleader seeks. Relief in the alternative or of several types may be demanded.

(b) Defenses; Forms of Denials. A party shall state in short and plain terms the party's defenses to each claim asserted and shall admit or deny the averments upon which the adverse party relies. If a party is without knowledge or information sufficient to form a belief as to the truth of an averment, the party shall so state and this had the effect of a denial. Denials shall fairly meet the substance of the averments denied. When a pleader intends in good faith to deny only a part or a qualification of an averment, the pleader shall specify so much of it as is true and material and shall deny only the remainder. Unless the pleader intends in good faith to controvert all the averments of the preceding pleading, the pleader may make denials as specific denials of designated averments or paragraphs or may generally deny all the averments or paragraphs as the pleader expressly admits; but, when the pleader does so intent to controvert all its averments, including averments of the grounds upon which the court's jurisdiction depends, the pleader may do so by general denial subject to the obligations set forth in Rule 11.

© Affirmative Defenses. In pleading to a preceding pleading, a party shall set forth affirmatively accord and satisfaction, arbitration and award, assumption risk, contributory negligence, discharge in bankruptcy, duress, estoppel, failure of consideration, fraud, illegality, injury by fellow servant, laches, license, payment, release, res judicata, statute of frauds, statute of limitations, waiver, and any other matter constituting an avoidance or affirmative defense. When a party has mistakenly designated a defense as a counterclaim or counterclaim as a defense, the court on terms, if justice so requires, shall treat the pleading as if there had been a proper designation.

(d) Effect of Failure to Deny. Averments in a pleading to which a responsive pleading is required, other than those as to the amount of damage, are admitted when not denied in the responsive pleading. Averments in a pleading to which no responsive pleading is required or permitted shall be taken as denied or avoided.

(e) Pleading to Be Concise and Direct; Consistency.

(1) Each averment of a pleading shall be simple, concise, and direct. No technical forms of peading or motions are required.

(2) A party may set forth two or more statements of a claim or defense alternately or hypothetically, either in one count or defense or in separate counts or defenses. When two or more statements are made in the alternative, and one of them if made independently would be sufficient, the pleading is not make insufficient by the insufficiency of one or more the alternative statements. A party may also state as many separate claims or defenses as the party has regardless of consistency and whether based on legal, equitable, or maritime grounds. All statements shall be

made subject to the obligations set forth in Rule 11.

(f) Construction of Pleading. All pleading shall be so construed as to do substantial justice.

FRCP 9(b) Fraud, Mistake, Condition of the Mind

In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

FRE 405. Methods of Proving Character

(a) Reputation or opinion. In all cases in which evidence of character or a trait of character of a person is admissible, proof may be made by testimony as to reputation or testimony in the form of an opinion. On cross examination, inquiry is allowable int relevant specific instances of conduct.

(b) Specific instances of conduct. In cases in which character or trait of character of a person is an essential element of a charge, claim, or defense, proof may also be made of specific instances of that persons conduct.

FRE 608. Evidence of Character and Conduct of Witness

(a) Opinion and reputation evidence of character. The credibility of a witness may be attacked or supported by evidence in the form of pinion or reputation, but subject to these limitations: (1) the evidence may refer only to character for truthfulness ir untruthfulness, and (2) evidence of truthful character is admissible only after the character of the witness for truthfulness has been attacked by opinion or reputation evidence or otherwise.

(b) Specific instances of conduct. Specific instances of conduct of a witness, for the purpose of attacking or supporting the witness' credibility, other than conviction of crime as provided in rule 609, may bot be proved by extrinsic evidence. They may, however, in the discretion of the court, if probative of truthfulness or untruth fulness, be inquired into on cross-examination of the witness (1) concerning the witness' character for truthfulness or untruthfulness, or (2) concerning the character for truthfulness or untruthfulness of another witness as to which character the witness being cross-examined has testified.

The giving of testimony, whether by an accused or by any other witness, does not operate as a waiver of the accused's or the witness' privilege against self-incrimination when examined with respect to matter which relate only to credibility.

ORDERS

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, ex rel. CONRNEILUS HARRIS Plaintiff	:	
v.	:	Civil Action No. 97-1605
GEORGE WASHINGTON PRIMARY ASSOCIATES, et al. Defendants	:	(JR)

Amended Order

Upon consideration of the motion of defendant George Washington, Primary Care Associated to dismiss, and relator's opposition thereto, and for the reasons set forth on the hearing of this motion In open Court on September 1, 1998 it is this 7th day of October 1998,

ORDERED pursuant to F.R. Civ. P. 9(b) that the complaint is dismissed as to all defendants. This dismissal is without prejudice.

/s/
James Robertson
United States District Judge

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 98-7192 **September Term, 1999**

United States of America, *ex rel* Corneilus Harris,
Appellant

v.

George Washington Primary Care Associates, et al.
Appellees

Appeal from the United States District Court
for the District of Columbia
(No. 97cv1605)

Before: Ginsburg, Rogers and Tatel, Circuit Judges.

Judgment

This appeal was considered in the record from the United States District Court for the District of Columbia and on the briefs filed by counsel. The issues have been accorded full consideration by the Court and occasion no need for a published opinion. *See* D.C Cir. Rule 36(b).

This is a *qui tam* action brought on behalf of the United States by Appellant, Cornelius Harris, alleging Medicare fraud by Appellees. The district court dismissed the

complaint without prejudice for failure to plead fraud with sufficient particularity. *See* Fed. R. Civ. P. 9(b)

In concluding that the complaint was not sufficiently specific, the district court applied the proper standard — "the pleader must state the time, place and content of the false misrepresentations, the fact misrepresented and what was obtained or given up as a consequence of the fraud." *United States ex rel. Joseph v. Cannon*, 642 F.2d 1373, 1385 (D.C. Cir. 1981), *cert. denied*, 405 U.S. 999 (1982). As the district court correctly noted, the complaint fails to plead the time, place or content of the alleged false misrepresentations and fails specifically to state the alleged illegal gain. The complaint generally alleges that fraud occurred over an eleven-year time span and that it involved overbilling and improper coding, but the complaint fails to allege any specific instances in which overbilling or improper coding or other fraudulent activity took place. The only tow types of improper billing that the complaint mentions are the failure to bill insurance companies before billing Medicare and billing for instances when residents performed services. As Appellees point out, however, failure to bill insurance companies and billing for residents' time is sometimes permissible under the Medicare regulations. Since the complaint alleges no specific instances of the fraud, Appellees simply have no way of knowing whether they even violated the law. Under these circumstances, dismissal pursuant to Rule 9(b) is appropriate.

Appellant maintains that we should apply a modified Rule 9(b) standard to *qui tam* actions, but this argument was squarely rejected in *United States ex. rel. Joseph v. Cannon*, 642 F.2d at 1385, which applies to Rule 9(b) *qui tam* actions. Appellant's argument that Fed. R. Civ. P. 8 requires us to relax the Rule 9(b) standard is without merit, since our cases

already have harmonized the Rule 9(b) and Rule 8 standards in applying the test articulated in *Cannon, See Kowal v. Mic. Communications Corp.*, 16 F.3d 1271, 1278 (D.C. Cir. 1994). Appellant claims that the district court was biased against him because counsel for Appellees mention at oral argument the circumstances of Appellant's departure, and the district court referred to Appellant as a "disgruntled employee". This claim falls short of impermissible bias.

Appellant also argues that he is entitled to discovery before the complaint is dismissed. As the district court noted, however, because the time span and allegations of this complaint are so general, discovery would be a massive undertaking. One of the purposes of Rule 9(b) is to prevent such "fishing expeditions" that are based only on vague and unsubstantiated claims. *See Vicom, Inc. v. Harbridge Merchant Services, Inc.* 20 F.3d 771, 777 (7th Cir. 1994).

Finally, Appellant argues in his reply brief that we should *sua sponte* remand the case to provide him with an opportunity to amend the complaint. Not only did Appellant fail to raise this argument in his opening brief, he never moved the district for leave to amend the complaint to cure the particularity deficiencies. We also note that if Appellant believes that he can allege facts with sufficient particularity to meet the Rule 9(b) standard, he can file a new action since the district court's dismissal of the case was without prejudice. It is therefore

ORDERED and ADJUDGED that the district court's order dismissing this case without prejudice be affirmed.

The clerk is directed to withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing.

FOR THE COURT:

Mark J. Langer, Clerk

By: /s/
Maryanne McCain
Deputy Clerk

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 98-7192 **September Term, 1999**

United States of America, *ex rel* Corneilus Harris,
Appellant

v.

George Washington Primary Care Associates, et al.
Appellees

BEFORE: Ginsburg, Rogers and Tatel, Circuit Judges

ORDER

Upon consideration of appellant's petition for rehearing filed on November 3, 1999 it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:

Mark J. Langer, Clerk

By: /s/
Robert A. Bonner
Deputy Clerk

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA,
Ex rel
CORNELIUS HARRIS

Plaintiffs,

v.

GEORGE WASHINGTON PRIMARY CARE ASSOCIATES

and

HEALTH CARE SCIENCES

and

MEDICAL FACULTY ASSOCIATES

and

GEORGE WASHINGTON DEPARTMENT OF MEDICINE

and

GEORGE WASHINGTON HOSPITAL

and

JUDITH McMANUS

and :
:
JOSHUA COHEN :
:
and :
:
JOHN DOE, I THRU X :
:
Defendants. :
:

AMENDED COMPLAINT FOR DAMAGES AND OTHER RELIEF UNDER THE FALSE CLAIMS ACT

JURISDICTION AND VENUE

1. This is an action to recover damages and civil penalties on behalf of the United States of America and its department and agencies. The claim arises out of the Defendants' act in presenting claims for medical payment under a federal program known as Medicare.

The action is based on 31 U.S.C. 3729, et. Seq., commonly known as the False Claims Act.

2. Jurisdiction is based on 31 U.S.C. 3732 (a). It is believed that all Defendants can be found or transacted business within the District of Columbia and thus the claim may properly be brought in this judicial district.

3. Pursuant to 31 U.S.C. 3730(b)(2) plaintiff filed this complaint in camera and under seal for more than 60 days.

4. The Government did not elect to intervene pursuant to 31 U.S.C. 3730(b)(2).

PARTIES

5. Plaintiff Cornelius Harris brings this action on behalf of the United States of America. Plaintiff appears before the court as a Qui Tam plaintiff. [Hereafter, Plaintiff Harris is referred to as "Relator"].

6. All Defendants participate in the provision of health care services in this jurisdiction and all Defendant's have charged the United States through

Medicare for the provision of services in the jurisdiction.

7. Documentary evidence in the control of Defendants and Medicare will show violations of Medicare law and rules including over billing, improper billing, charges without proper documentation, up coding, improper medicare write offs and other improper acts.

8. "Relator" was employed by and for the benefit of the entity defendants. From October of 1996 until August 1997, "Relator" served as "Reimbursement Specialist" for the George Washington University Medical Center. The job embraced and included all defendant entities. In that capacity, "Relator" was charged with performing various tasks directly tied and related to Medicare reimbursement for all defendant entities. In his position, Relator received, on a daily basis, documents know as "fee tickets". Said fee tickets were processed by defendants and their agents and

employees and rendered to Medicare for payment and on information and belief, routinely paid. "Relator" personally reviewed various information which leads to him to believe these practices date back at least to 1986 and " Relator" personally heard admissions that lead him to believe the practices alleged date back to at least 1986.

9. In his position as Reimbursement Specialist, "Relator" had regular contact with various directors, executives, physicians, nurses and other employees of defendants.

10. "Relator" verily believes that defendants regularly and purposefully submitted false claims to Medicare and that the gross number of false claims number in the thousands. "Relator" verily believes that based on the overcharges and the$10,000 in statutory penalties for each false claim submitted, the fact that defendants' acts were knowing and deliberate, and the

authority for assessment of damages up to and including treble damages that the gross amount to be recovered from the defendant exceeds thirty million dollars ($30,000,000.00).

11. Defendant George Washington Hospital is a hospital located in and doing business in the District of Columbia.

12. Defendant George Washington Primary Care Associates is an entity that provided out patient clinic and ambulatory care center services.

13. Defendant Health Care Sciences was the predecessor to George Washington Primary Care Associates.

14. Defendant George Washington Department of Medicine is an entity that provides out patient clinic and ambulatory care services.

15. Defendant Medical Faculty Associates is an entity that oversees all ambulatory care operations of

all the enumerated entities (except George Washington Hospital) and provides out patient clinic and ambulatory care services.

16. Defendant Judith McManus served as the administrator of George Washington Primary Care Associates and as an agent of the defendant.

17. Defendant Joshua Cohen, M.D. served as a member of Governing Board of the Hospital and an agent or director of defendant.

18. All the entity defendants used identical or parallel billing procedures. "Relator" verily believes that all defendants committed the acts of over billing, improper billing and billing without proper documentation enumerated in paragraph 6 hereof and/or all Defendants participated in a system in furtherance of such acts. Relator further believes that medicare reimbursements may have been commingled between the entity defendants thus resulting in a common action to

defraud medicare.

19. Specific acts committed by defendants in derogation of the Medicare statute and regulations include but are not limited to over billing, improper "coding" of medical procedures resulting in over billing, improper billing of services performed by "resident" physicians in instances when "attending" physician were not present, billing without proper use of "modifier" codes, billing despite the lack of proper documentation, failure to collect patients payment share in derogation of applicable law or regulation as well as "up coding" and other acts related to the aforegoing all of which let to an increase overall Medicare reimbursements due to multiple individual acts of over billing, in addition, there may be other acts which may be discerned in discovery.

20. Defendant' John Doe I thru X are fictitious defendant names set forth herein. Relator believes that their acts of omission or commission in

connection with and in furtherance of the violations of law herein enumerated will or may require their enumeration as party defendants.

INTERCONNECTION OF PARTIES
INTERCONNECTION OF RECORDS
COMMINGLING OF MEDICARE FUNDS

Relator observed and verily believes that the "entity defendants" (George Washington Hospital, George Washington Primary Care Associates, Health Care Sciences, George Washington Department of Medicine and Medical Faculty Associates) regularly and routinely mixed their services, medicare billings and medicare receipts.

Thus it would be common for one of the doctors and one intern to visit a patient first at the hospital (George Washington Hospital) and then a day or two later at the "ACC" or outpatient facility. In such instances the patient might have one chart for both visits, one doctor who sees him/her and that doctor is

billing through the hospital and "Primary Care Associates". In this example the doctor is billing in part under Medicare Part A and in part under Medicare Part B. The charges billed to Medicare are technically earned by the hospital an din this scenario by Medical Faculty Associates (the employer of the intern) and Primary Care Associates (the doctor at the ACC or outpatient care building).

Relator verily believes that when such Medicare drafts were received it was common for it to be "deposited" or credited to one entity and not subdivided. Hence relator avers that there was an individual and a common practice of all Defendant entities that defrauded Medicare.

Relator had personal responsibility for billing matters that overlapped all 5 of the entities references herein and relator personally observed hundreds of "transactions" where this commingling of duties,

medicare billing and fees was the rule.

Rather than reiterate this issue in each paragraph of the complaint relator will use the words "all Defendant entities" committed these acts [in violation of Medicare statute and regulations].

FIRST CAUSE OF ACTION

21. From 1986 until the present time, defendants have engaged in the acts of over billing, improper coding and lack of documentation and other acts herein before described. Through this improper charging, defendants improperly obtained millions of dollars from the United States Government.

22. The entity defendants violated various provisions of the code of Federal Regulations found in 42 CFR, Chapter IV as well as the Medicare statute. Specific acts committed by defendants included the employment of erroneous CPT and ICD-9 codes this

resulting in overpayment. Other violations including improper submission of charges for "resident" doctors and improper documentation.

23. Pursuant to 42 CFR, Chapter IV the United States Government through the Health Care Finance Administration (HCFA) paid to the entity defendants millions of dollars of "reimbursements" based on the improper and illegal billings submitted by defendants.

24. From 1986 through July 1997 the entity defendants knowingly defrauded the United States Government by knowingly submitting the aforesaid improper billings.

25. "Relator" attempted to change the aforesaid policies but was told by his superiors and Defendant entities agents specifically, Judith McManus, administrator of George Washington Primary Care Associates, Barbara Griffith of Medical Faculty

Associates and Joshua Cohen, a member of the Governing Board of the Hospital to "leave it alone" and that to conduct an internal review would later " be discoverable" and in other ways told to not do the right thing. Hence, based on these statements of defendant's agents and employees and directors "Relator"avers that defendants' acts were knowing, deliberate and continuing. "Relator" also asked Edward Jenkins, COO of Medical Faculty Associates and Barbara Griffith of Medical Faculty Associates to change this system and they would not.

26. All Defendant entities committed these acts in violation of Medicare statute and regulations. Defendants acting through their Directors and Administrators, doctors, employees and agents knowingly defrauded the United States of America and its Medicare program by knowingly overbilling, and submitting bills based on erroneous coding and improper

documentation and by failing to collect sums it was required to collect under Medicare regulations.

27. "Relator" verily believes that based on the fraudulent bills submitted to the Medicare program, each defendant received large sums of money as "reimbursement" that were fraudulently obtained. "Relator" further avers that defendants had no right in law t the sums received.

SECOND CAUSE OF ACTION

28. "Relator" herein adopts and restates paragraphs 1 through 27 as if set forth in full herein. "Relator" further avers that due to the statements of Administrator McManus to "leave it alone" and Director Joshua Cohen to not do the right thing, to "leave it alone" and to not undertake an internal review or audit because it would be discoverable, and other acts of omission and commission by other agents, employees, officers and directors of the entity defendants that the

actions of defendants were knowingly and willfully fraudulent. Relator verily states that all Defendant entities committed these acts in violation of Medicare statute of regulations.

THIRD CAUSE OF ACTION

29. "Relator" herein adopts and restates paragraphs 1 through 28 as if set forth in full herein.

30. Relator specifically states that all Defendant entities committed acts as follows and the examples set forth as specific t the entity named in the subpart are not unique to that entity but rather, common to all Defendant entities:

a) Defendant Medical Faculty Associates for itself and as agent of a nursing home type facility known as Thomas House failed to collect "matching shares" in situations where subrogation and/or reimbursement was required and where assignments and authorizations were required (or on

hand) and/or where co-insurance was available. Relator saw Health Care Financing Administration forms where Defendants deliberately deceived medicare. Such deception was at times effected by indicating, for example, that a car accident was not involved when it was in fact involved. This act was done repeatedly, was known to defendants including Plaintiffs agent Pamela McClain and violates Medicare "reasonable collection" requirements. In fact relator verily believes that all Defendant entities grossly failed to collect deductibles in 100's of instances.

b)

c) Relator also gave an oral presentation at the hospital auditorium to more than fifty of the entity defendants doctors in a similar attempt to get defendants' to properly document medical procedures and to properly code medical procedures.

As relator made such efforts relator was told to "leave it alone Neil" and you can't [do this] "because its discoverable". Statements of this type were made to relator by director Joshua Cohen, M.D. and administrator Judith McManus. Defendants acts are thus believed to be knowingly and willfully fraudulent.

d) Defendant Medical Faculty Associates acting for and as agent of the entity and a nursing home facility known as Thomas House was regularly failing to collect "matching shares" or co-insurance (payments) in violation of fair collection act provisions. This was known to various of Defendant's employees including medical director Jerome Paulsen, M.D. and Joy Laramee, nurse practitioner. These and other employees and agents of defendant entities failed to changes existing practice despite relator's urging that they do so.

e) Health Care Sciences records were

reviewed by relator and he personally observed records dating back as much as ten years wherein there was overcoding, billing without documentation, billing by residents where there was no authorization in the chart and the like. Relator met with this defendant's executive Gregory Paulsen, M.D. and Marion Parrot, M.D. who at relator's suggestion said they would look into changing these procedures but never did so.

f) Relator personally met 4 times with George Washington Hospital director Joshua Cohen, M.D. who was in charge of defendants QEV or "quality evaluation" efforts and relator urged Dr. Cohen to change the aforesaid billing without documentation, the over coding and failure to collect matching shares and Dr. Cohen told him "don't do anything now" and "legal matters might be involved". Relator believes these matters overlapped to all defendant entities.

g) Defendant George Washington

Primary Care Associates regularly "up coded", failed to obtain matching share and permitted residents to bill medicare. All those acts were in records reviewed by relator. Relator made Dr. John Voss aware these violations of medicare rules and regulations but he failed to change those acts and those acts continued.

h) Defendant Health Care Sciences similarly billed medicare without proper documentation, also improperly permitted resident billing, up coded and failed to document. This was known to its director Gregory Paulsen, M.D. who failed to correct these acts. Relator personally reviewed approximately 75 charts which evidenced lack of proper documentation yet billing ensued.

i) Defendant Medical Faculty Associates was particularly negligent in collecting funds due to medicare. This included failure to pursue subrogation, failure to bill co-insurance and failure to

require and include in the file assignment and authorization forms to collect on assignment and authorizations. This was known to its director Dr. Shesser who failed to correct these acts.

j) The George Washington Department of Medicine regularly permitted resident billing in violation of medicare law and regulation and (as witnessed by relator) regularly permitted coding errors particularly in regard to GC and GE modifiers. Said department also regularly billed without proper documentation. Department directors Gary Malakoff, M.D., Dr. John Voss and Elizabeth Cobbs, M.D. were cognizant of the violations but despite voiced statements failed to follow through and correct these improper acts.

k) Relator personally saw medical charts where medicare was billed but he attending doctor was not in attendance, this violating applicable law and regulation. Relator has personal knowledge

that on occasions when an attending physician was not in attendance at Defendant's facility and the patient was seen by an intern or resident that Medicare was billed. This can be confirmed by matching hospital patient charts to doctor attendance records to medicare billings. One example is a Dr. Selleck who saw patients while the attending doctor was not in the building. By checking her charts and those of Dr. Chin and by looking for GC or GE coding and by subpoenaing the provider schedule it can be shown that the attending doctor was not in attendance and hence medicare was improperly billed. This procedure of billing when "the attending" was not present was common and deliberate.

l) That relator alerted officials of Defendants to Medicare billing matter that he was certain were improper and that relator urged these individuals to correct this and was told to leave it alone (or similar language). Individuals who knew of these

matters include Gary Malakoff, M.D., Elizabeth Cobbs, M.D., John Voss, M.D., Joshua Cohen, M.D., Judith McManus-Murray, administrator of George Washington Primary Care Associates and others. Dr. Cohen was the QEV or quality control official of Defendant entities and Ms. McManus-Murray responsibility for several entities including George Washington Primary Care Associates and GW Hospital billing.

m) That relator observed errors in coding resulting in Medicare over billing committed by Defendant entities and that these relate to various violations specifically including "levels of care". Review of CPT codes and ICD-9 codes when matched to medicare bills and patient records will further substantiate said assertions. Records of Dr. Schroth and Dr. Omran and others will substantiate these assertions.

n) That relator observed charges for preventive medicine deliberately miscoded to attempt to

obtain medicare reimbursement for uncovered service. Relator observed that Dr. Schroth often billed codes 99214 and 99215 and when he should have billed lower level codes, this resulting in billing for his time rather than task, this is in violation of medicare regulations.

o) That relator personally saw records where there is no documentation of treatment yet the procedure/treatment was billed (improperly) to Medicare and that this can be shown by comparison of those records.

p) That in an effort to correct such matters relator personally conducted a training session on or about February of 1997 at Defendant's hospital where relator attempted to instruct Defendant entities team leaders and doctors about proper coding, compliance, etc.

q) That relator is personally aware of improper Medicare "write-offs" and that this can

corroborated by review of medicare billings and Defendant's records. As an example Defendant, through its facility "Thomas House", a resident facility, collected its portion of medicare payment for parties (approximately 80%) and then in contravention of medicare law and regulation failed to collect the "match" (20% est.) This applies to all Defendant entities. This violates medicare rules relative to "reasonable collections of coinsurance". This can be substantiated through Defendant's management reports and other documents particularly when matched to medicare is remittance information that is tendered with payments.

r) That relator saw fee tickets where there was no documentation of levels of care. This is in violation of medicare law and regulation yet medicare was billed and relator believes Defendants were paid. Relator saw related errors wherein the diagnosis was not provided. This was common and can likely be examined

in relation to code V70.0. Relator believes defendant entity upon receiving medicare notices of rejection went back and changed the code and upcoded. Relator verily believes that Defendants where not only aware of this category of errors but worked further to use their awareness to improperly bill medicare by examining cases where medicare rejected the charge and the defendants then changed the diagnosis and re-submitted the bill to medicare.

s) Errors in billing codes were endemic but defendant entities took no steps to correct this. Thus for example although relator told Dr. Moore (a supervisory doctor) that a doctor on his "team" named Dr. Schroth was billing under wrong codes nothing was done to correct this.

t) Relator saw that nurse practitioners would not use a required E&M code rather than the doctor's code thus leading to over billing

u) The entity defendants by its Director of Business Office (particularly Medical Faculty Associates) at Willow Oaks refused to properly implement subrogation efforts required by Medicare. As an example, if a patient were in a car accident this person (Pam McClain) refused to collect from the responsible car insurance and instead routinely billed medicare. Defendants routinely failed to have the required signed A&A (authorization and assignment) in the file in violation of medicare regulations. Relator believes many medicare billings were improper because this signed form was not in the file.

v) As part of relator's duties patients would call with billing questions. This would require relator to obtain patient charts to review the billing. Relator often saw charts where required S.O.A.P. notes and diagnostic codes were not included yet medicare was billed. Relator saw such errors and discussed

proper procedures with numerous doctors yet of defendant entities the erroneous measures that are described were continued.

Some of Defendant's agents or employees (such as Judith McManus-Murray, administrator) said do not look into it further as it would be "discoverable". Yet others such as Dr. Gibbs said "I don't care if it is discoverable we need to start fixing it ". Dr. Voss and others said no don't touch anything. These discussions in part let relator to make a presentation in February 1998 to defendant entities doctors.

w) George Washington University Primary Care Associates routinely failed to turn in fee tickets in violation of Medicare regulations. Doctors routinely kept fee tickets because they felt rushed. Relator tired to implement a tracking number system to correct this. The prior lack of track system resulted in overcharging and undercharging. (In Medicare

terminology this is fraud for not accurately reporting medical services for Medicare's yearly provider reimbursement evaluation).

x) Relator saw instances of incorrect coding for ICD-9 and CPT Codes. Further that fee tickets for billing by residents were routinely submitted in error because of GW Hospital mixed their bills with those of credentialed doctors. Incorrect billings were thus routinely submitted to Medicare and reimbursement followed.

y) Relator saw that Defendants billed charges for doctors who lacked Medicare certification (credentials).

z) Relator saw records that revealed that Defendants were not coding according to Medicare rules. This was non compliance with the requirement but coding for treatment (rather than time).

aa) In cases where a person was in a

car accident Defendants were required to bill the car insurance first. Instead Defendants routinely billed Medicare. This violates Medicare regulations. The director of the Medical Faculty Associates Business Office (Pamela McClain) refused to carry out the proper procedure because this made her accounts receivables seem too large and too slow on collection.

bb) Defendants regularly violated Medicare regulations by not reporting charges. This was particularly true of Defendant GWU Primary Care Associates. That entity has approximately 7 regional facilities and relator believe this problem was rampant in that organization. When fee tickets are not submitted services are not accurately reported. Relator believes some doctors did this on purpose because too many services provided by Dr. X would result in a lesser reimbursement rate from Medicare in the next year.

cc) All Defendant entities violated

Medicare rules on diagnosis code billing. Specifically all Defendant entities regularly permitted billing under ICD9 code V70.0. This a code for preventive medicine or routine examinations. He saw thousands of such billings. These were regularly rejected by Medicare and the Defendant entities would re-bill Medicare using diagnosis codes that they felt would guarantee reimbursement and Defendant entities did this without carefully checking medical records to see it the re-billed codes were accurate.

dd) Relator reviewed patient charts on a daily basis and relator also pulled and examined over hundred 9100) medical charts at one time that involved all 5 Defendant entities and compared them to the Medicare management report that listed only medicare patients who incurred charges. He created an internal management report that said Defendant entities were regularly billing Medicare in situations where proper

documentation was not in the medical charts (and specifically also no in the progress notes). He gave this memo to administrator Judith McManus, Drs. Cobb, Malakoff, Gregory Paulsen and others and they did not take any action to correct billing procedures.

ee) Defendant Medical Faculty Associates also participated in and facilitated the wrongful medicare billing by knowingly transmitting electronically all Defendants bills to Pam McClain and Willow Oaks to send the improper billings to Medicare.

WHEREFORE:

"Relator" prays for judgment against each defendant as follows:

a) That defendants and each of them have violated the False Claims Act.

b) That defendants and each of them, acting through their agents, employers and directors knowingly and willfully violated the False

Claims Act.

c) That by reason of defendants' acts as enumerated in a) and b) above, judgment be entered against defendants and each of them that they caused the United States Government to lose large sums of money and further that for those acts defendants and each of them judgment be entered against them for thirty million dollars ($30,000,000.00) in actual damages and that treble damages be further assessed.

d) That be reason of defendants acts, defendant be assessed civil penalties of no less than $5,000.00 and no more than $10,000.00 for each violation of 31 U.S.C. Sec. 3729.

e) That "Relator" be awarded the maximum amount allowed pursuant to the False Claims Act and all other applicable provisions law.

f) That "Relator" be awarded

all costs of this action, and attorney fees.

g) That "Relator" be awarded such other and further relief as may be just.

By

David E. Fox, #165258

1325 18th Street, N.W.

Suite 103

Washington, DC 20036

(202) 955-5300

VERIFICATION

Cornelius Harris affirms that he has read the matters and things stated herein and that

he believes that they are true.

/
S
/

_____

Corneluis Harris

Subscribed and sworn to before me this _____ day of _____, 2000.

_____

Notary Public

My Commission Expires:

Appendix B 35

CERTIFICATE OF SERVICE

I hereby certify that on this _____ day of _____, 2000, a copy of

the foregoing was mailed, postage prepaid to Besty Wanger, Esquire, 2100 Pennsylvania

Avenue, NW, Suite 690, Washington, DC 20037

_____

David E. Fox

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA
ex rel. CORNELIUS HARRIS,

Docket No. CA 97-1605 JR

Plaintiff,

Washington, D.C.

v. Tuesday, September 1, 1998

10:00 a.m.

GEORGE WASHINGTON PRIMARY
CARE ASSOCIATES, et al.,

Defendant.

. . . . . .

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE JAMES

Dennis A. Dinkel - Official Court Reporter -
202-289-8661

ROBERTSON
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiff: DAVID E. FOX, ESQ.
1325 18th Street, N.W.
Washington, D.C. 20036

For the Defendants: ARNOLD & PORTER
J. STEPHEN LAWRENCE, JR., ESQ.
555 12th Street, N.W.
Washington, D.C. 20004-1202
BETSY K. WANGER, ESQ.
Office of the Vice President
and General Counsel
The George Washington University
2100 Pennsylvania Avenue, N.W.
Washington, D.C. 20052

Court Reporter : Dennis A. Dinkel
Official Court Reporter

Room 6818, U S. Courthouse
Washington, D C. 20001
(202) 289-8661

Proceedings reported by machine shorthand, transcript produced by computer-aided transcription

P R O C E E D I N G S

(10:00 a.m.)

THE DEPUTY CLERK: Civil Action 97-1603

Cornelius Harris versus George Washington Primary

Care Associates, et al. Counsel please identify yourselv

for the record.

MR. FOX: I'm David Fox. I represent the plaintiff, Neil Harris, who is here with me today.

MR. LAWRENCE: I am Steve Lawrence.

THE COURT: I know you, Mr. Lawrence.

MR. LAWRENCE: This is Betsy Wanger from the office of general counsel at George Washington University. We represent the defendants and Dr. Joshua Cohen.

THE COURT: Ms. Wanger.

Well, the major motion before me is a motion to dismiss. I think there are some subsidiary motions, but

that's going to drive this discussion. Mr. Lawrence, are you going to argue the motion to dismiss?

MR. LAWRENCE: Yes, sir, I am.

THE COURT: All right. Proceed.

MR. LAWRENCE: With your permission, I need to sit down to make this argument.

THE COURT: Of course. You have the hand mike, do you not?

MR. LAWRENCE: I do, thank you.

THE COURT: First of all, Mr. Lawrence, I believe I understand and respect your constitutionality

claim, and I will hear what you want to say about it. You are speaking to a District Court Judge. This has not escaped your attention. I think it is very unlikely that that constitutionality claim is going to prevail at this level. You can -- you may make your record. You may ask the Court of Appeals or the Supremes to review it, but I don't think it's a lack of judicial courage. I think it's simply a deference to precedent from other courts. The real party in interest in a qui tam case is thought to be the United States.

By statute the United States may delegate, has

delegated its authority to individuals. I understand the case of controversy claim. It is not an uninteresting one, but, frankly, I am much more interested for today's purposes in your rule 9(b) argument and in your statute of limitations argument.

MR. LAWRENCE: I appreciate your remarks, Your Honor. We're prepared to rest on our papers as far as the constitutional argument goes and not to argue it today and to sort of leave it where it stands. Our principal motion, our principal argument is the 9(b) motion, in fact, the motion to dismiss for failure to state

fraud with particularity.

Those issues have also been briefed extensively before the Court already; and except for one issue relating to 9(b), we are prepared to rest on our papers with respect to that argument, too.

That issue that I want to address this morning is why we believe the Court would be justified in dismissing the complaint with prejudice, which is what we've asked for. We understand that that is a severe sanction for a pleading defect; but I'd like to talk about a number of factors that I think are justified -- that I think justify it in

this particular case.

The first one is the carelessness with which we believe this complaint has been pled. In fact, I believe that carelessness is the hallmark of this complaint, particularly the amended complaint. It takes it out of the realm of an ordinary pleading that simply fails to provide enough information.

I'd like to give two examples of that. The first has to do with the timeframe covered by the complaint. Mr. Harris, the plaintiff in this case, was an employee at George Washington University for only 10 months from

October of 1996 until July of 1997. Despite this, his complaint purports to cover the 10-year -- nine-plus years prior to his employment at the university. He expands his complaint from 10 months to 10 years through just two almost offhanded sentences in the complaint saying that he observed certain documents, unspecified, and heard certain verbal admissions, unspecified, that the practices that he's complaining of indicate back to at least 1986.

Rule 9(b) applies to allegations that he may want to make about the period prior to his employment, just as

they do to the period of his employment. Yet he makes no effort whatsoever in any way, shape, or form to particularize those allegations as they might relate to the period from 1986 until he started to work at the university in 1996.

The plaintiff may not realize it, but accusations lik this even if they are careless and baseless and truncated have real -- have consequences in the real world. For example, once the university became aware of this suit, i had no choice but to put a freeze on the destruction of any documents that were under its control, that would

otherwise have been destroyed pursuant to a standard document retention policy. I mean, this kind of consequence has real economic impact.

This is separate and apart from any damage to reputation that might come about from being publicly disclosed, publicly accused, after decades, of massive Medicare fraud or from gearing up to defend a case involving nine years instead of 10 months.

The only purpose I can discern for putting an allegation like this in this complaint and the way that it was pled is to try to portray this as a case of enormous

magnitude and, thereby, put additional pressure on the defendants to settle rather than to litigate.

I think this is exactly the kind of nuisance pleadin that rule 9(b) was designed to prevent, and it is one of the reasons why I think dismissal with prejudice would warranted here.

Another example of the carelessness that I'm talking about has to do with another principle underlyin rule 9(b); and that has to do with protecting against frivolous accusations of moral turpitude. One of the re purposes underlying the rule is that if you are going to

accuse anyone -- a party, an institution, the defendant, an individual -- of fraud, you better have details so that person can defend himself or the institution can defend itself.

Now, we had put forward in our paper exactly why we think the defendants in this case have been accused in ways that won't allow them to defend themselves. But what I'd like to focus on here is that in the amended complaint, the plaintiff goes beyond talking about the defendants and names 20 individuals -- by name 20 individual George Washington employees both

physicians and medical administrators and accuses each and every one of them of some kind of improper conduct

But once again, in ways that are very, very nonspecific so that they can't -- the university can't defend their actions on behalf of the institution; but I think more to the point here, these employees can't defend themselves to their employer if they are accused of broad things like failure to document their work, failure to bill for things that they should have billed for, failure to follow proper procedures, and on and on and on.

I think it is significant that 18 of the 20 individuals that I'm talking about were named in the amended complaint which came after the government declined to intervene in the case; and I think this was a misguided attempt to add specificity to the lawsuit; but, you know, under certain circumstances, it is certainly okay to name individuals; but only if you -- if you provide along with that the information that will allow them to defend themselves; and that didn't happen here, so this is not particularity in the way that rule 9(b) calls for it. It is really just disparagement and is quite disturbing.

I think these two examples of carelessness when sort of added to the other problems with the complaint that we talked about in our papers justify a dismissal wi prejudice. One thing to keep in mind is that -- I mean th trend line in terms of this lawsuit seems to be going dow in terms of getting useful information. Even though the amended complaint added eight pages of information, it really was nonspecific,, and it really did take this extra step of naming these employees in a way that won't allo them to answer effectively.

The second point I want to make about dismissal

with prejudice goes to the point that Mr. Fox made in his papers which is that he should be allowed some leniency in his pleading here because the documents are within the defendants' control; and, therefore, it would be unfair to expect them to know the information in them. I think that in the facts of this case, that's just wrong. There is no excuse for this plaintiff not pleading with particularity. It is important to keep in mind that this lawsuit was filed in July 1997 while Mr. Harris was still an employee at George Washington University.

I mean, in his complaint he tells us that he was

extensively involved in all of the billing practices of all th named defendants, that he has expertise in this area, and in fact he had more expertise than any of his colleagues. He tells us that he developed a management report on problems that existed in documentation of Medicare charges.

In his opposing papers, Mr. Fox tells us that Mr. Harris, you know, saw GW's Medicare files with his eyes and he touched them with his hands. He tells us that he saw the fraud. This is not a plaintiff who has been denied access to relevant information. This is not a plaintiff

who, as Mr. Fox suggests, needs to steal documents in order to make a particularized case. This is a plaintiff who had access to the information and just didn't use it.

Under those circumstances, I mean, leniency is just not called for.

I think that this plaintiff for each claim of fraud against these defendants ought to be required to state the time, the place, the content, and the consequence of the fraud which is the established legal standard in this circuit and in most other places in the country.

He hasn't done that. So under these

circumstances, dismissal with prejudice would not be unfair.

The third point about dismissal with prejudice has to do with looking toward the future and asking what might reasonably be expected if this plaintiff were allowed to file another complaint. I think there's no evidence that another complaint could pass muster under rule 9(b). There are two points here. One is that if you take another look at the complaints, two of them in this case already, going from complaint A to complaint B, to the amended complaint did not advance the ball in terms

of complying with rule 9(b). If anything, I think detracted from it by disparaging these GW employees without specificity.

So there is just a tremendous gap from where we are now to where we need to be under rule 9(b). Just too much of a leap of faith to think this plaintiff is going to be able to do that.

In fact, the second point I want to make about this relates to the clues that we have about what this plaintiff might do if he were allowed to refile his complaint. Mr. Fox says in his opposing papers that he needs discovery

in order to particularize his complaint. Well, if there's anything that's clear under rule 9(b) is that the purpose of discovery in a fraud case is to allow a plaintiff to prove his claim and not find his claim. So we have a situation where we have an amended complaint that doesn't pass muster under rule 9(b), and we have Mr. Fox telling us that he can't really improve that unless he gets information he's not entitled to.

So I don't think the future is very promising in terms of a rule 9(b)-compliant complaint from this plaintiff in the future; so dismissal with prejudice is

appropriate.

THE COURT: Thank you, Mr. Lawrence.

Mr. Fox?

MR. FOX: Thank you, Your Honor.

THE COURT: Mr. Fox, have a seat. Mr. Lawrence, I have a question before we go to Mr. Fox.

You want me to dismiss this claim with prejudice. The real party in interest in a qui tam case is the United States of America. If I dismiss this claim with prejudice, does that mean the United States of America can never go after George Washington University for

Medicare-Medicaid billing fraud for the last 10-year period?

MR. LAWRENCE: Your Honor, as we pointed out in our papers, the government has a vast array of techniques it can use to go after Medicare-Medicaid, whatever, health care fraud in general. It also has -- these are techniques that go beyond the False Claims Act.

If your question is will this have some kind of preclusive effect on the United States of America, I think it would only have preclusive effect about things that were actually tried and factual findings made with respect

to them. I don't think we are talking about a case here with great collateral estoppel effect, if any.

THE COURT: Okay.

Mr. Fox?

MR. FOX: Thank you, Your Honor.

Your Honor, I join Mr. Lawrence in the feeling it is not necessary to reiterate the various points which have been submitted to the Court by way of our pleadings.

There are, however, six or seven salient points relating to 9(b) which I would like to bring to the attention of the court at this time.

First, Your Honor, we would not be here if I had told Neil Harris when he left that job at GW to walk out with patient files. If he had walked out with the computer information and the patient records and the Medicare billing that was on his desk in July of 1997, we would not be making a rule 9(b) argument.

So this really does relate to the instruction the Court gives to future plaintiffs. Do you attempt to memorize the names of thousands of patients? Memorize the type of medical procedure that was performed? Memorize the type of Medicare billing? Or do you walk

out with the files? Or do you instead file with the Court a complaint which attempts to specify the generic types of fraud and enough specifics to show the Court that you, the plaintiff, have the information that's necessary to prove your case?

Now, Your Honor, under the decision in, I think, Gibson versus Connolly -- Connolly versus Gibson, Your Honor, the opinion is rendered that a case should not be dismissed unless it appears without doubt that the party cannot prove his case. It is not a decision which says to the Court, you know, some type of balancing is

appropriate. It is not a decision which says to the Court a preponderance or some other standard.

This case is mentioned in our brief. The cite is in our brief. But the point is, Your Honor, that this relator worked at George Washington Hospital and observed things, as Mr. Lawrence has said, with his own eyes and touched them with his own hand.

Now, Your Honor, Mr. Harris was the reimbursement specialist. This means as a practical matter, Your Honor, that the bills came across his desk. Now, Mr. Lawrence is correct: Mr. Harris was there for

a limited period of time. He was there for about nine months; and then in July of 1997, he was in the hospital for three weeks. The complaint here was filed on July 14. His last day at work was August 4, 1997.

So as of the day he filed this complaint, he was virtually out of that position.

THE COURT: What were the circumstances of his departure?

MR. FOX: He was under pressure from some of his managers to do a number of things which he thought was improper; and this does give rise to the second point

I was going to argue, Your Honor. For him to stay in that job, he would have been virtually compelled to become a coconspirator with George Washington Hospital and its affiliates in a culture of fraud.

Now, Mr. Lawrence says that Mr. Harris was not there a long time; how can he bring before the Court the type of complaint that goes back 10 years? How can he say to the Court that he is prepared to prove fraud going back 10 years?

The answer, Your Honor, is that as the reimbursement specialist, he has on his desk accounts

receivable reports, old Medicare records, patient records; and he sees something is wrong.

As a matter of fact, Your Honor, I think that as an employee, he could be congratulated. He takes the job. It takes him a while to learn the job. Once he learns it, he starts -- as Your Honor knows from the pleadings -- he starts talking to people at the hospital saying this isn't right; have to change it. And they push him off. They want to continue this culture of fraud.

And at that point, he gives lectures. He has a room of doctors before him and tries to teach them how

to do coding. Let's stop this upcoding. Let's stop this billing without proper documentation and a number of other specifics. What is an employee to do, Your Hono If he stays there at GW, he then would be, in effect, guilty of being a participant in this fraud. He's under pressure from his boss for a multitude of things, some perhaps performance-related, but others related to this problem of fraud.

He has a health problem at the same time. He decides enough is enough and he leaves GW. But the second reason we think this complaint should go forwa

is that, in effect, we have a person there trying to do the right thing. The legislative history is replete with statements, Your Honor, that the government needs help ferreting out fraud. I have the legislative history here. I could give Your Honor a few cites if that would be helpful.

But the point is the government is saying -- excuse me, the Congress is saying to us that the government needs help finding this fraud. If people like Neil Harris cannot bring it to the Court, then there is a problem with the statute and enforcing the statute.

Now, Your Honor, there's case law -- I'd like to bring two cases to Your Honor's attention One is the case we cited in our brief which is the Gravitt versus General Electric case where the Court holds that tens of thousands of false labor vouchers were involved, and it not necessary to produce the names.

Now, I would if this were a discussion, Your Honor, I would turn to Mr. Lawrence and say, Mr. Lawrence, what would be different if Neil Harris had listed in his complaint six or 10 patient records.

What really would help you defend this case bette

Mr. Lawrence, if Neil Harris said Mr. Smith, patient on such and such a date, had a gall bladder that should have been billed under X, instead it was billed under Y, and you, GW, took an extra $500 from Medicare? Would those six citations prove this case? I don't think that's the point.

I think the decision I cited to the Court is more closer to the truth. This is a case that's going to involve thousands of records; and if Mr. Harris had memorized 10 patient charts, 10 matching Medicare reimbursement records, that wouldn't prove anything.

What needs to be done in this case, Your Honor, it needs to go forward the way any case goes forward. There needs to be basic discovery. When Neil Harris saw what was going on at GW, when he saw this culture of fraud, he started working on it. And there are record at GW that he can identify which would bring all of this together with names and dates. I don't think the names and dates are needed at this point in time; and I definitel feel that for the purposes of defense, having six or 10 or 15 names now would not do any good.

But because of the pleadings which Mr. Lawrence

has filed with the Court, I've pushed Mr. Harris for names; and he came up with a name. He said I remember the Nguyen family N-G-U-Y-E-N. I believe it's pronounced Nguyen. I remember the Nguyen family. It was an auto accident. There were standard two violations, the things GW always does wrong. There's upcoding, which means a higher reimbursement; and then there's a failure to get reimbursement from the auto insurance company. Also a Medicare violation. There's five or six people involved in this auto accident. From his memory, he gives me this one example.

I fail to understand how a dozen examples such as this would assist Mr. Lawrence. I think the better rule, Your Honor, is that rule 8 which requires a short and plain statement of the claim; and as we've shown the Court in our pleadings, the case law does suggest there be a balancing between rule 8 and rule 9(b), that these rules have to be looked at or read in harmony.

Also, Your Honor Wright and Miller in their federal practice series do try to address this question. Essentially what they say is that the Court should have a flexible approach. That it would be wrong to have too

narrow a reading.

And I think they are right because if you take the facts of this case -- especially given the fact of privacy of medical records -- there is simply no way that these cases could ever be brought if the Court were to accept Mr. Lawrence's argument and put those hurdles in the way of a relator.

I offered in my brief I think three or four pages of citations to local area jurisdiction laws that protect patient privacy. Medical confidentiality. In effect, a relator would have to jump through hurdles and know all

of those 20 or 30 laws, or he couldn't satisfy Mr. Lawrence. Because what is Mr. Lawrence really saying to the Court, Your Honor? He's saying to the Court the particularity is not there. I want names and dates.

Well, Your Honor the names and dates are there, but there's something practical about litigation. Just as Mr. Lawrence has a fear that GW is now losing money because they can't destroy records, we have a fear; and our fear is that these cases would never go forward if the Court were to support the defendant and create that hurdle.

Your Honor, this is particularly true in Medicare cases. There are going to be thousands of patient records, thousands of matching -- or rather corresponding -- Medicare records and thousands of regulations laid before Your Honor. Hopefully, we will do that in a coherent way. But if Your Honor would consider a second look at another of the cases we cited which is the Michaels case, essentially the Michaels case talks about a number of factors that help the Court see whether or not the fraud is identified.

And those factors -- I think there's 11 of them,

Your Honor -- we've satisfied the 11 factors in the Michaels case. We've identified the parties, we've identified the participants, we've identified the type of representation, we've identified the nature in which it wa misleading; we've identified the general time, although w can't give a date. We can tell Your Honor the general time. We can tell the place. The place is in the hospital The place is in the billing records for the medical practice, from the nursing home. We can tell you that. We can tell you the content of the misrepresentation. W can tell you that Mr. Harris saw upcoding.

We can't tell you the name of the patient, but he can tell you that he prepared a computer list of over 1100 of these cases, Your Honor. 1100 that he prepared which is still in the records. All we need is basic discovery to get that 1100 list and with one discovery request we will lay before the Court 1100 examples.

Now, Your Honor, the Michaels case also talks about a fraudulent scheme, it talks about a fraudulent intent, it talks about reliance on fraud. Certainly with the amount of money that the institution was making, they were relying on the fraud. And it talks about the injury

resulting.

Well, the injury resulting to the government who we -- who we are one step removed but who we technically represent, the injury is millions of dollars of losses. So using the 11 factors in the Michaels case, Your Honor, I think we've satisfied the requirements of the statute. And under Connolly versus Gibson it cannot be said that the case can be dismissed.

Now, Your Honor, we can only say that there is certainly upon reading 9(b) a conflict with the word "particularity". But I think we -- well, what I would say

to the Court if closing is what is Mr. Lawrence trying to do? He's trying to use the procedural law, the procedural rule to gut a federal law of some importance.

That was not the intent of 9(b). That's why Michaels and all these other cases have defeated Mr. Lawrence's position. We would ask the Court very simply to allow this case to proceed through the normal discovery that the Court sees in every other case. We will lay before the Court hundreds, if not thousands of fraudulent claims.

And I think, Your Honor, to do less would be to

allow this culture of fraud to continue.

Thank you.

THE COURT: Anything further, Mr. Lawrence?

MR. LAWRENCE: If I may, Your Honor, just a couple of points. The first has to do with your question to Mr. Fox about the circumstances of Mr. Harris' departure from the university. I mean, in our papers, w were quite -- we know a lot about that. We know why happened. We have records to substantiate it and so forth. We stayed very carefully away from that at this pleading stage. Since you asked the question, I'm -- I'm

tempted to engage in a rebuttal with Mr. Fox, but I'm not going to. I will only represent to the Court that those were not the circumstances of his departure.

Another point Mr. Fox raised, I guess it is the theme, Your Honor, that runs through Mr. Fox's papers, opposing papers and presentation this morning which is that this case ought to proceed like ordinary litigation. I think the fundamental point to keep in mind is that fraud cases are treated differently than ordinary litigation where noticed pleading of the most general type is allowed. This is a case where in this circuit time, place, content,

and consequence of the fraud are required to be stated.

That's the decision that came out of Judge Robinson's decision in the Cannon case in 1981. It has been in effect for the entire modern era of the qui tam law, which has been since 1986. This Court both at the Court of Appeals and the District Court has not shied away from applying it. The Michaels case we distinguished in our brief. I don't care what they say the factors are that the Michaels court actually listed what the plaintiff in that case provided, which is a far cry from what the plaintiff in this case provided.

One other point, Your Honor, that has to do with this question of naming patient names. In our motion to dismiss, I used the word "patient names" once. I regret it. It was given as an example of something that might add specificity to this generalized complaint. We are not seeking patient names. George Washington University is very sensitive to those kinds of issues. Will not give out patient names. Mr. Fox has already violated one patient's privacy this morning here in court.

Let's talk about the case he talked about, the auto accident. It is a good example of the kind of pleading

that can't be done. He said that case involved upcoding. Upcoding is charging for a service, charging for a service that provides greater reimbursement when it is not justified.

In a fraud claim, a plaintiff is required to state the facts that are misrepresented. Why is that upcoding? The car insurance point is even more telling. I mean, throughout his complaint, Mr. Harris talks about problems or defects in the way that George Washington University handled car insurance matters vis-a-vis Medicare. You can't just say you violated the car

insurance regulations. As we pointed out in our papers, there are lots of regulations in that area. Under some circumstances, institutions are required to bill Medicare for car accidents.

So if all you say is that family was involved in a car accident and GW didn't follow Medicare regulations, we have to know the particularities in order to know whether we have a 12(b)(6) motion to file in that regard. That's just one example of the kind of information that we need and why we need it.

The final point that I will rebut has to do with the

fact that what we're asking for somehow stifles whistleblowers. Mr. Harris has not been stifled. Mr. Harris went to the government with a complaint in July of 1997, and the government investigated the complaint and declined to intervene.

This is not some short-circuiting of the process. I wouldn't begin to speak on behalf of the government as to why they did it, why they didn't intervene. I have my guesses. This is not a plaintiff who has been denied all of his opportunities to be a whistleblower. It is just that he hasn't met the standards.

Thank you, Your Honor.

THE COURT: Well, Mr. Fox, this complaint doesn't make it.

It is completely vague, no real specifics. Fraud cases -- Mr. Lawrence is right: Fraud cases are not ordinary litigation. But more than that, qui tam cases are not ordinary fraud litigation.

Mr. Harris took this claim to the United States government. The United States government for its own reasons, whatever they were, declined to pursue it. We can all guess about why they declined to pursue it, but

the best guess probably is that after interviewing Mr. Harris, they decided he didn't know enough to pursue a claim against George Washington University.

Mr. Lawrence is also correct that the complaint doesn't begin to set forth time, place, content, and consequences of the claimed fraud. To require GW to respond to what I'm sure would be a massive discovery request on the generalized allegations of this complaint filed by a person who appears to be a disaffected former employee of George Washington University is to put legal tools and weapons in the plaintiff's hand that could

not have been contemplated by the qui tam statute.

Qui tam cases typically are brought by relators who, as distasteful as this may sound to you, Mr. Fox, do stick around, do collect information, do put together detailed dossiers, briefs of facts, enough to either persuade the government to take the case and either go forward with it or at least to satisfy rule 9(b).

That's what the bounty is all about in qui tam cases. Bounty isn't just sort of an en passant windfall to somebody who was there and thought oh, gee, I saw something bad, I'm going to file a complaint and then I'm

going to get some discovery and find out what it is; I think this case is terminally weak, Mr. Fox, and it will be dismissed.

The dismissal has to be without prejudice. I can't see a with-prejudice dismissal under either rule 9(b) or under the qui tam statute. I don't know what the collateral effects would be of a with-prejudice dismissal; but I will tell you, sir, that unless you are prepared to file a complaint that is very dramatically more specific within the meaning of rule 9(b) than what you filed now, I will dismiss it again. So it may very well be that what you

need to do is to test the sufficiency of the amended complaint that you filed in another court.

I just think it's much, much too nonspecific to permit this case to go forward or to give rise to any right on the part of your client to take discovery.

I keep bearing in mind that this is not Mr. Harris' case. This is the United States government's case; and Mr. Harris is permitted by the qui tam statute if he can do so consistently with the rules to pursue a claim that the government has declined to prosecute.

But dismissing the claim -- the complaint is not in

the first instance dismissing Mr. Harris' claim, because Mr. Harris' claim is only to a bounty.

MR. FOX: If I may, Your Honor?

THE COURT: Yes.

MR. FOX: It would be the request of the plaintiff that the Court not enter such an order at this time but rather that the Court consider limited discovery to see whether or not the things I've represented to the Court are correct.

For example, as by way of limited discovery, I've told the Court that the relator has described to me a list

that was on his desk of more than 1100 cases of Medicare fraud. All he would have to do is go back into his old office, in his old computer; and whatever time it takes the computer to find that list, generate a list of 1100 cases.

I have a thought about some limited discovery of that type which would present to the Court the facts which the Court feels are now lacking that would certainly not inconvenience or cause any problem for George Washington or in any way be inconsistent with the rules of the Court.

Limited discovery, I think, would be appropriate and would be a healthier thing than further court review of the kinds of pleadings which we filed or whether or not under a health care fraud case, where there is such patient privacy, whether or not this is a different animal than other types of fraud.

THE COURT: I will not do so, Mr. Fox.

It seems to me that even the recovery of a list of 1100 names of cases that the plaintiff thinks or thought were cases of Medicare fraud would only raise the question of what you then do with those 1100 names. Do

you go into those records? Do you take the depositions of all the health care providers? How are you going to prove the upcoding in each one of those cases? You have to prove the underlying facts of each medical case, try to figure out -- I mean --

MR. FOX: I can answer that, Your Honor.

THE COURT: Well, you can answer it, Mr. Fox; but I'm not going to permit limited discovery. I'm not going to permit any discovery on this complaint.

MR. FOX: May I say one thing for the record?

THE COURT: You may.

MR. FOX: Thank you. I appreciate that. What we could do at that point, Your Honor, is we could either bring in an expert who would address the questions you raise as to whether that constitutes fraud or Mr. Harris might himself be an expert. Either way, we could take those 1100 cases and show this Court exactly why there's Medicare fraud and why we've given the Court 1100 examples.

Thank you.

THE COURT: All right, sir. You made your statement.

MR. FOX: I appreciate Your Honor's forbearance.

THE COURT: The case will be dismissed without prejudice pursuant to Federal Rule of Civil Procedure 9(b), failure to state with the requisite specificity the fraud alleged in the complaint. I will issue a very short order to that effect.

I do not intend and I don't think I need to file an opinion on this basis. It is all set forth in the record as it stands.

Anything further?

MR. FOX: Nothing further, Your Honor. Thank

you.

THE COURT: Mr. Lawrence?

MR. LAWRENCE: No, thank you.

THE COURT: Thank you.

THE DEPUTY CLERK: Court stands adjourned until 11:00 o'clock.

(Proceedings adjourned at 10:42 a.m.)

CERTIFICATE

I, DENNIS A. DINKEL, Official Court Reporter certify that the foregoing pages are a correct transcript from the record of proceedings in the above-entitled matter.

_____

Dennis A. Dinkel - Official Court Reporter - 202-289-8661